

CERTIFICATE OF DEATH

Reg. Dist. No. 100

3610

1. PLACE OF DEATH:

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X

TOWN

Lablata

LENGTH OF STAY (in this place)

5 hrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS

66

Physician Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Charles

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

OR

Bel Air

X

STREET ADDRESS

(If rural, give location)

3. NAME OF DECEASED:

(First)

Loretta

(Middle)

Ceelia

(Last)

Adams

4. DATE

(Month)

(Day)

(Year)

OF

DEATH:

April 13

1955

5. SEX:

7

6. COLOR OR RACE

Cal.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

S.

8. DATE OF BIRTH:

Feb 26, 1954

9. AGE last birthday:

1

yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

None

10b. KIND OF BUSINESS OR INDUSTRY:

—

11. BIRTHPLACE (State or foreign country):

Md.

12. CITIZEN OF WHAT COUNTRY?

US

13. FATHER'S NAME:

Leroy Swann

14. MOTHER'S MAIDEN NAME:

Gladys Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

—

17. INFORMANT & ADDRESS:

Joe Adams, Bel Air, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

490X

Immediate cause

(a)

DUE TO

Respiratory failure.

INTERVAL BETWEEN ONSET AND DEATH

3 min

Antecedent cause(s)

(b)

DUE TO

Pneumonia, bilateral.

5 days.

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

—

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 April, 1955, to 18 April, 1955, that I last saw the deceased alive on 18 April, 1955, and that death occurred at 11:10 p.m., from the causes and on the date stated above.

SIGNATURE

J. Wooddy

(DEGREE OR TITLE)

MD

ADDRESS

Lablata

DATE SIGNED

19 April 55

23. BURIAL, CREMATION REMOVAL (Specify):

Burial

DATE RECEIVED

4/24/55

NAME OF CEMETERY OR CREMATORY

Sacred Heart

LOCATION (City, town, or county)

Lablata, Md.

(State)

DATE RECEIVED BY LOCAL REG.

4/20/55

REGISTRAR'S SIGNATURE

Julia H. Boney

24. FUNERAL DIRECTOR

Brehart Funeral Home Lablata Md.

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

APR 22 1955

RECEIVED

3611

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Lablata

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

66 Phyllis Memorial

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md.

COUNTY

Pr. Geo.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Brandywine 16X-2

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED:

(First)

Joseph

(Middle)

H.

(Last)

BLANDFORD

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

April 3

19 55

5. SEX:

M

6. COLOR OR RACE:

US W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Married

8. DATE OF BIRTH:

Jan. 28, 1877

9. AGE last birthday:

78

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Physician

10b. KIND OF BUSINESS OR INDUSTRY:

Retired

11. BIRTHPLACE (State or foreign country):

Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

Joseph H. Blandford

14. MOTHER'S MAIDEN NAME:

Cynthia Mudd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Pauline Blandford

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause

(a)

Respiratory failure

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

Crown occlusion

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

10 min.

3 days.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3.1 Mar., 19.55., to 3. Apr., 19.55., that I last saw the deceased alive on 3. April, 19.55., and that death occurred at 2.40 A.M., from the causes and on the date stated above.

SIGNATURE

J. Wooddy

(DEGREE OR TITLE) ADDRESS

MD

La Plata.

DATE SIGNED

3. Apr. 55.

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4/6/55

Julia H. Passey

Heath & Ryan, Valley Md.

MARGIN RESERVED FOR BINDING

RECEIVED

APR 7 1955

BUREAU V. S.

3612

CERTIFICATE OF DEATH

Reg. Dist. No. 100

I. PLACE OF DEATH:

COUNTY *Cheslen* MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN *Lablata* LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS *Phymer's Memorial*

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE *md* COUNTY *Cheslen*
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN *Newburg*STREET ADDRESS (If rural, give location) *1*

3. NAME OF DECEASED:

(First) (Middle) (Last)
*JOHN RANDOLPH COOKSEY*4. DATE OF DEATH: (Month) (Day) (Year)
*7 5 1955*5. SEX: *M*6. COLOR OR RACE: *W*7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): *M*8. DATE OF BIRTH: *8-23-73*9. AGE last birthday: *81* yrs. IF UNDER 1 YEAR: Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): *Farmer*10b. KIND OF BUSINESS OR INDUSTRY: *Farming*11. BIRTHPLACE (State or foreign country): *md*12. CITIZEN OF WHAT COUNTRY? *U.S.*

13. FATHER'S NAME:

JOHN SOMERSET COOKSEN

14. MOTHER'S MAIDEN NAME:

*ELIZABETH SWANN*15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) *no*

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: *John Cooksey, Newburg, md*

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

442X
Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

*Cardio - Vascular Disease 3-18-55**Gen. Art Sclerosis 1952*

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED White at work ☐ Not white at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *3-18-55*, to *4-5-55*, that I last saw the deceased alive on *4-3-55*, and that death occurred at *1 P.M.*, from the causes and on the date stated above.SIGNATURE *E. J. Schellum*(DEGREE OR TITLE) ADDRESS *MD. Lablata md*DATE SIGNED *4-5-55*

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF *4/7/55*NAME OF CEMETERY OR CREMATORY *Cheslet Church*LOCATION (City, town, or county) (State) *Wayside, md.*DATE REC'D BY LOCAL REG. *4/6/55*REGISTRAR'S SIGNATURE *Julia H. Casey*

24. FUNERAL DIRECTOR

ADDRESS *Arboretum Funeral Home, Lablata, md*

MARGIN RESERVED FOR BINDING

RECEIVED

APR 7 1955

BUREAU V. S.

3613

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

La Plata

LENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

Brynmor Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Charles

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNSTREET
ADDRESS

Newburg

(If rural, give location)

3. NAME OF
DECEASED:
(Type or Print)

(First)

MARY

(Middle)

VIRGINIA

(Last)

COOKSEY

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

4 9 19

55

5. SEX:

F

6. COLOR OR
RACE:

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

W

8. DATE OF BIRTH:

4-5-73

9. AGE last birthday:

82 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

Hawf

10b. KIND OF BUSINESS OR
INDUSTRY:

own home

11. BIRTHPLACE (State or foreign country):

Md

12. CITIZEN OF WHAT
COUNTRY?

us

13. FATHER'S NAME:

JOHN T

DUTTON

14. MOTHER'S MAIDEN NAME:

ALICE WIN GATE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

John B. Carney, Newburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause

(a) DUE TO

Cerebro-Vascular Accident

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating underlying cause last

(b) DUE TO

Hypertension

(c)

INTERVAL BETWEEN
ONSET AND DEATH

2-24-55

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF
office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURYINJURY OCCURRED
While at Not while
M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 19 55, to 4 9 19 55 that I last saw the deceased

alive on 4 9 19 55, and that death occurred at 2 45 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Julia Hasey

Archart Funeral Home, La Plata, Md

MARGIN RESERVED FOR BINDING

RECEIVED

APR 14 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3614		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		03602	
Item 18 & 21 Film G181 5-10-55		CERTIFICATE OF DEATH		Reg. Dist. No. 100	
1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Charles Co md.</u>	MARYLAND		STATE <u>md</u>	COUNTY <u>Charles Co</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Belton md.</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Belton md.</u>	STREET ADDRESS (If rural, give location)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH: (Month) (Day) (Year)		
<u>ELIZABETH HARRIC + CARVER</u>			<u>4 24 1955</u>		
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Wid</u>	8. DATE OF BIRTH: <u>4-17-82</u>	9. AGE last birthday: <u>73</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Charles Co md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>no. s.a.</u>
13. FATHER'S NAME: <u>B. Welch</u>			14. MOTHER'S MAIDEN NAME: <u>Elizabeth Farrell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.:		
			17. INFORMANT & ADDRESS: <u>Mrs. Herman Welch, Spring Hill md.</u>		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
491X Immediate cause (a) <u>Chronic Pneumonia</u> DUE TO					
Antecedent cause(s) (b) <u>Fractured hip</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>6-54</u>					
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:			19b. MAJOR FINDINGS OF OPERATION:		
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>					
21. ACCIDENT (Specify) SUICIDE HOMICIDE <u>Accident</u>			PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>		
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
			HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>6-54</u> , 19 <u>54</u> , to <u>4-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>9-14</u> , 19 <u>55</u> , and that death occurred at <u>9:14</u> a.m., from the causes and on the date stated above.					
SIGNATURE <u>E. Hedekem</u>			DATE SIGNED <u>4-27-55</u>		
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>			NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		
DATE THEREOF <u>4-25-55</u>			LOCATION (City, town, or county) (State) <u>Lapata md.</u>		
DATE REC'D BY LOCAL REG. <u>4/27/55</u>			24. FUNERAL DIRECTOR <u>Archard Funeral Home Inc.</u>		
REGISTER'S SIGNATURE <u>Julia H. Green</u>			ADDRESS <u>Lapata md.</u>		

BUREAU V. S.

APR 29 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03603

CERTIFICATE OF DEATH

Reg. Dist. No. 100

3615

Item 9, Film 181 5-6-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>md.</i> COUNTY <i>Chas</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Lafayette, Md.</i>		LENGTH OF STAY (in this place) <i>10 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Grayton Md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<i>THOMAS OLANDA RYE</i>				<i>4 26 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>S</i>	8. DATE OF BIRTH: <i>Oct 14 1875</i>	9. AGE last birthday: <i>79 4/8</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Farmer</i>		11. BIRTHPLACE (State or foreign country): <i>Chas Co md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME: <i>William C</i>				14. MOTHER'S MAIDEN NAME: <i>Mary Ann Gray</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <i>non</i>		17. INFORMANT & ADDRESS: <i>Mr Claude Janssen</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
177X Immediate cause (a) <i>Uremia</i>						<i>4-16-55</i>	
Antecedent cause(s) (b) <i>Cancer of Prostate</i>						<i>??</i>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
21. ACCIDENT (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
SUICIDE				INJURY			
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>4-16-55</i> , 19 <i>55</i> , to <i>4-26-55</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>4-26-55</i> , 19 <i>55</i> , and that death occurred at <i>4-26-55</i> m. from the causes and on the date stated above.							
SIGNATURE <i>R. J. Edelen</i>				(DEGREE OR TITLE) <i>M.D.</i>		ADDRESS <i>Lafayette Md.</i>	
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>4-29-55</i>		NAME OF CEMETERY OR CREMATORY: <i>Old Durham Church</i>		LOCATION (City, town, or county) (State): <i>Iron sides md.</i>	
DATE REG'D BY LOCAL REG: <i>4/29/55</i>		REGISTRAR'S SIGNATURE: <i>Julia Hasey</i>		24. FUNERAL DIRECTOR: <i>Archard Funeral Home Inc</i>		ADDRESS: <i>Lafayette md.</i>	

BUREAU V. S.

MAY 2 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3618

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE. 18

03604

CERTIFICATE OF DEATH

Reg. Dist. No. 100.....

~~Item 9. FilmC182 6-6-55 et~~

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	CHARLES	STATE	Md. COUNTY Charles
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Bel Air	CITY (If outside corporate limits, write RURAL and give nearest town)	Bel Air
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
Richard Swann		4-3-55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
M		Single	June 14, 1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
Laborer		Farmer	Bel Air
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Neal Thomas		Ella Swann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		17. INFORMANT & ADDRESS:	
(If Yes, give war or dates of service)		216-12-4537 Ella Swann	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
331X Immediate cause (a) Cerebral Vascular Accident			3-16-55
Antecedent cause(s) (b) Hypertension			1950
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST			
II. OTHER SIGNIFICANT CONDITIONS:			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		20. AUTOPSY?	
19b. MAJOR FINDINGS OF OPERATION:		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
		CITY OR TOWN	
		COUNTY	
		STATE	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED	
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1950, to 4-3-55, that I last saw the deceased alive on 4-3-55, and that death occurred at 7:30 p.m., from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
E. E. Edelin		4-3-55	
23. BURIAL, CREMATION REMOVAL (Specify):		NAME OF CEMETERY OR CREMATORY	
Burial		St Thomas	
DATE REC'D BY LOCAL REG.		FUNERAL DIRECTOR	
4/4/55		Richard Funeral Home	
REGISTRAR'S SIGNATURE		ADDRESS	
Julia H. Boney		Bel Air	

RECEIVED

APR 7 1955

BUREAU V. S.

03605

MARYLAND STATE DEPARTMENT OF HEALTH

3617

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Chas</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldoy</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Waldoy</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>rural</u>	
3. NAME OF DECEASED (Type or Print) <u>Delie</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>THOMAS</u> (Month) (Day) (Year) <u>4</u> <u>6</u> <u>55</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, OR FORCED, (Specify) <u>MA</u>	8. DATE OF BIRTH <u>Dec 1880</u>
9. AGE last birthday <u>73</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>own home</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>Will Lyles</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Pinkney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Loretta Barbara Thelma</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>primary Occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4-6-55</u>	
Antecedent cause(s) (b) <u>Arthritis</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		1953.	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>C. Delie M.D.</u> (Degree or title)		ADDRESS <u>La Plata Md</u> DATE SIGNED <u>4-6-55</u>	
23. BURIAL CREMATION (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>4-9-55</u>		REGISTRAR'S SIGNATURE <u>M. L. Moore</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Waldoy Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 11 1915

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3618

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03606

 Item 18 Film G181 5-10-55 ams
 Items 11, 12, Film G181 5-3-55 at

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Charles</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Charles</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>La Plata</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Pyramus Memorial Hospital</i>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) <i>JOSEPHINE</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>4 26 19 55</i>			
5. SEX: <i>F</i>		6. COLOR OR RACE: <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Wid</i>		8. DATE OF BIRTH: <i>1-22-79</i>	
9. AGE last birthday: <i>76</i> yrs.		IF UNDER 1 YEAR: Months Days		IF UNDER 24 HRS: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Asst</i>				10h. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Berkeley Missouri</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME: <i>John Satymies</i>				14. MOTHER'S MAIDEN NAME: <i>Eleanora ?</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unkn) (If Yes, give war or date of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Ben Vennemann, Waldorf, Md</i>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
576x Immediate cause (a) DUE TO <i>Peritonitis</i>						<i>4-15-55</i>	
Antecedent cause(s) (b) DUE TO <i>Ruptured viscus (organ unknown)</i>						<i>4-15-55</i>	
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-14-55</i> to <i>4-26-55</i> , that I last saw the deceased alive on <i>4-26-55</i> and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>E. J. DeLeon</i>				DATE SIGNED <i>4-26-55</i>			
(DEGREE OR TITLE)				ADDRESS <i>La Plata Md</i>			
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>		DATE THEREOF: <i>4/28/55</i>		NAME OF CEMETERY OR CREMATORY: <i>St. Marys</i>		LOCATION (City, town, or county) (State): <i>Bryantown, Md</i>	
DATE REC'D BY LOCAL REG: <i>4/27/55</i>		REGISTRAR'S SIGNATURE: <i>Julia H. Green</i>		FUNERAL DIRECTOR: <i>Hunt & Ryan, Waldorf, Md.</i>		ADDRESS:	

BUREAU V. S.

APR 29 1955

RECEIVED

3619

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

COUNTY La Plata, Charles

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

X TOWN La Plata Md.Three daysHOSPITAL OR INSTITUTION OR PHYSICIANS MEMORIAL HOSPITAL
STREET ADDRESS La Plata Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.COUNTY Charles

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN

STREET ADDRESS Bryans Road (If rural, give location)

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

(Type or Print)

Galard Galaway WashingtonApril 21 1955

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday

IF UNDER 1 YEAR IF UNDER 24 HRS.

MaleNegroMarried5-29-0253 yrs.

Months

Days

Hours

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Henry Washington

14. MOTHER'S MAIDEN NAME:

Elizabeth Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Cecilia S. WashingtonBryans Road, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause

(a) Cerebral Hemorrhage

DUE TO

INTERVAL BETWEEN ONSET AND DEATH

3-Months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Hypertension

DUE TO

5-Years(c) Arterio SclerosisIndefinite

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-12-55 19....., to 4-21-55, 19....., that I last saw the deceased alive on 4-21-55, 19....., and that death occurred at 5-45 A.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

James E. Andrews MD.17-Potomac Ave Indian Head Md. 4-21-55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE/THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

4/21/55Julius H. HaseyBurns + Matheson684-4th St. S.W. Washington, D.C.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 25 1955

BUREAU V. S.

3620

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH: Charles Indian Head Md. COUNTY MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland Charles STATE COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Indian Head Md.				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Indian Head			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural, give location) 1			
3. NAME OF DECEASED: (Type or Print) Mary Catherine Weeks				4. DATE OF DEATH: 4-30-55 19			
5. SEX: Female		6. COLOR OR RACE: W-US		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: 5-16-1871 83 yrs.	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife				9. AGE last birthday: 83			
10a. CITIZENSHIP (Give kind of work done during most of working life, even if retired): House Wife				11. BIRTHPLACE (State or foreign country): Faguar-County Virginia			
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME: Unknown				14. MOTHER'S MAIDEN NAME: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY No.: -			
17. INFORMANT & ADDRESS: Shirley A. Woods, (Grand Daughter)							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
450.0 Immediate cause (a) Malnutrition DUE TO						one Year	
Antecedent cause(s) (b) Senility DUE TO						Indefinite	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last Arterio Sclerosis						Indefinite	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE				PLACE (Home, farm, factory, street, OF office bldg., etc.)			
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Not while M. work <input type="checkbox"/> at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 1, 1919 to 4-30-55, that I last saw the deceased alive on 4-30-55, 19, and that death occurred at 10AM, from the causes and on the date stated above.							
SIGNATURE James E. Andrews MD.				(DEGREE OR TITLE) ADDRESS Indian Head Md.			
DATE SIGNED 4-30-55							
23. BURIAL, CREMATION REMOVAL (Specify): Burial				DATE THEREOF 5-2-55			
NAME OF CEMETERY OR CREMATORY Piquet ME.				LOCATION (City, town, or county) Piquet Md.			
DATE REC'D BY LOCAL REG. 5/3/55				REGISTRAR'S SIGNATURE Mrs. Odey Prince			
				24. FUNERAL DIRECTOR Hunt & Ryan Waldo, Md.			
				ADDRESS			

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 4 1955

BUREAU Y. S.

Reg. Dist. No.....

3621

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:						2. USUAL RESIDENCE (HOME) OF DECEASED:							
COUNTY CHARLES				MARYLAND		STATE MD.				COUNTY CHARLES			
CITY (If outside corporate limits, write RURAL OR and give nearest town)				LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WALDORF							
HOSPITAL OR INSTITUTION OR STREET ADDRESS LA PLATA Hospt.						STREET ADDRESS (If rural, give location)							
3. NAME OF DECEASED: (First) SARAH (Middle) WEINER (Last)						4. DATE OF DEATH: APRIL 25 1957							
5. SEX: F		6. COLOR OR RACE: W		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOW		8. DATE OF BIRTH:		9. AGE last birthday: 66 yrs.		IF UNDER 1 YEAR Montha Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): RUSSIA				12. CITIZEN OF WHAT COUNTRY? U.S.B.			
13. FATHER'S NAME: HERSHAL						14. MOTHER'S MAIDEN NAME: ALICE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO				16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS:							
18. MEDICAL CERTIFICATION													
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1 Immediate cause Antecedent cause(s) Diseases or conditions, if any giving rise to the above cause stating underlying cause last												INTERVAL BETWEEN ONSET AND DEATH 1 min. 3 hrs.	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.													
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:								20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		M.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from July 1953 to 25 April 1955, that I last saw the deceased alive on 25 April 1955, and that death occurred at 10:20 p.m., from the causes and on the date stated above. SIGNATURE J. Woody (DEGREE OR TITLE) ADDRESS MD La Plata. Md. DATE SIGNED 25 Apr 55													
23. BURIAL, CREMATION REMOVAL (Specify): BURIAL		DATE THEREOF 4-27-1955		NAME OF CEMETERY OR CREMATORY ROSEDALE				LOCATION (City, town, or county) BALTO. MD				(State)	
DATE REC'D BY LOCAL REG. 4-22-55		REGISTRAR'S SIGNATURE H.W. Hedrick		24. FUNERAL DIRECTOR Jack Lewis Inc - 2100 Eutaw Pl.				ADDRESS					

